

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006821

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1027

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAR 8 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 42 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5111 Harvard		d. STREET ADDRESS (If outside, give location) 5111 Harvard	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) LAWRENCE C. MEINSEN			4. DATE OF DEATH Month Feb. Day 13 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1903	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Higginsville, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Chris H. Meinsen		13b. MOTHER'S MAIDEN NAME Lydia Tebbenkamp		14. NAME OF HUSBAND OR WIFE Mabel Meinsen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Mrs. Mabel Meinsen, 5111 Harvard	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 15 MIN.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Asthma - Chronic		Yrs
DUE TO (c) Branchial Pneumonia		4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Kansas City, Missouri	
21. I attended the deceased from 8 Feb 63 to 12 Feb 63 and last saw him alive on 12 Feb 63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert M. Myers M.D.		22b. ADDRESS 906 Grand Ave	
22c. DATE SIGNED 15 Feb 63		22d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 16, 1963	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 2-15-63	
26. REGISTRAR'S SIGNATURE Ruth Long		26. REGISTRAR'S SIGNATURE	

Woodland-Linwood

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF ROBERT M. MYERS MEDICAL CERTIFICATION

DATE AMENDED

VS 300 Rev. 4/59

3 x 48

3

4 0

5 1

6

7 0

8 0

9 241X

10

11

12 90-0

13

Dr. Robert M. Meyer
Resells Body
No 2-4751

1- 4:30 PM wed
Not at all Thurs
2-4 Fri

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James E. Kaufman

Licensed Embalmer No. 4573

P. O. Address J. C. GMD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.